Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

INNOVA HOSPITAL
4243 EAST SOUTHCROSS BLVD
SAN ANTONIO TX 78222

Respondent Name
UNIVERSITY HEALTH SYSTEM

Carrier's Austin Representative Box
Box Number 42

MFDR Tracking Number
M4-11-3697-01

MFDR Date Received
JUNE 27, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our total billed amount was $534,046.00. With the corrected claim, the only change was to Revenue Code 0278, implant supplies. Originally the billed amount for the implants was $360,810.00. With the correction to the implants list, the new billed amount was $355,526.00. To date, after repeated requests for reconsideration, we have only received $15,455.30 for the implants…We also request that the implants be paid separately, and not bundled with other supplies or services. The cost for the implants used in this surgery was $88,881.50. With the $2,000.00 allowed add-on, the total cost for reimbursement is $90,881.50. **With the payment of $15,455.30 that we received after our first request for reconsideration, that still leaves $75,426.20 remaining to be reimbursed for the implants.**"

Amount in Dispute: $75,426.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The initial bill submission did not request separate reimbursement for implants. Therefore, in accordance with rule 134.404 the Medicare value of $69,321.02 was multiplied by 143% for a total reimbursement of $99,558.06. This amount was issued under check #26541 on December 14, 2010." "On appeal the provider requested implants to be paid separately. In an effort to act in good faith, the reimbursement was recalculated. After deducting the implant amount of $360,810.00 from the total hospital bill of $534,046.00 the Medicare reimbursement value was $37,370.56. Applying the markup of 108% the recommended reimbursement was $40,360.21 plus $74,653.15 for implants for a total reimbursement of $115,013.36. Deducting the prior reimbursement of $99,558.06 an additional allowance of $15,455.30 was recommended. This was issued under check #27026 on February 4, 2011." "The surgery implant record has been reviewed again and an additional amount of $11,633.35 is being recommended."

Response Submitted by: Argus, 9101 LBJ Freeway, Suite 600, Dallas, Texas 75243-2055

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 22, 2010 Through October 26, 2010	Inpatient Hospital Surgical Services - Implantables Only Revenue Code 278	$75,426.20	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated December 2, 2010
   - W1QA – Workers Compensation State Fee Schedule Adjustment. *Medicare inpatient hospital specific reimbursement amount multiplied by 143%. DWC rule 134.404.*
   - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*
   - Total Paid This Audit – $99,558.06 [$0.00 paid on implantables]

   Explanation of benefits dated February 2, 2011
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*
   - W1RA – Workers Compensation State Fee Schedule Adjustment. *Medicare inpatient hospital specific reimbursement amount multiplied by 108%. DWC rule 134.404.*
   - W3 – Additional payment made on appeal/reconsideration.
   - W1UA – Workers Compensation State Fee Schedule Adjustment. *Implantables are reimbaursed [sic] at the lesser of the manufacturers invoice amount or the net
   - Comments: RE-CONSIDERATION OF EOB 539200…AMNIOSHIELD TISSUE BARRIER, AQUAMANTYS & DURASEAL DO NOT APPEAR TO BE IMPLANTS. NOR DO MPLANT [sic] RECORDS INDICATE DBM & DBM 10CC
   - Total Paid This Audit – $15,455.30 [Implantables only]

   Explanation of benefits dated May 17, 2011
   - 193Z – No denial description listed on EOB
   - 97 – No denial description listed on EOB
   - Comments: RE-CONSIDERATION OF EOB 547280-DMB 20CC INVOICE ATTACHED DTD 10/27/10 SHIPPED 10/25/10 WHICH IS AFTER CLMTS SURGERY-UNABLE TO LOCATE DBM 10CC INVOICE

   Explanation of benefits dated July 7, 2011
   - 193Z – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. *Thank-you for your inquiry. No additional reimbursement allowed after review of appeal/reconsideraiont.*
   - W1RA – Workers Compensation State Fee Schedule Adjustment. *Medicare inpatient hospital specific reimbursement amount multiplied by 108%. DWC rule 134.404.*
   - 97H – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. *Service(s)/Procedure is included in the value of another service/procedure billed on the same date.*
   - W3A – Additional payment made on appeal/reconsideration. *Thank-you for your inquiry. Upon re-review, additional benefit is recommended.*
   - Comments: Re-consideration of EOB 539200

   Total Paid This Audit – $11,633.35 [Implantables only]

Issues

1. Were the disputed services subject to a specific fee schedule set in a contract between the parties that complies with the requirements of Labor Code §413.011?
2. Which reimbursement calculation applies to the services in dispute?
3. What is the maximum allowable reimbursement for the services in dispute?
4. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:
   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or
   (2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

   No documentation was found to support the existence of a contractual agreement between the parties to this dispute; therefore the MAR can be established under §134.404(f).

2. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
      (A) 143 percent; unless
      (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

   Review of the documentation finds that that the facility requested separate reimbursement for implantables; for that reason, the requirements of subsection (g) apply.

3. 28 Texas Administrative Code §134.404(g) states, in pertinent part, that "(g) Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission.
   (1) A facility or surgical implant provider billing separately for an implantable shall include with the billing a certification that the amount billed represents the actual costs (net amount, exclusive of rebates and discounts) for the implantable. The certification shall include the following sentence: "I hereby certify under penalty of law that the following is the true and correct actual cost to the best of my knowledge."

   Review of the documentation found supports that the following items were certified as required by (g):

Itemized Statement Rev Code or Charge Code	Itemized Statement Description	Cost Invoice Description	# Units & Cost Per Unit	Cost Invoice Amount	***Per item*** Add-on (cost +10% or $1,000 whichever is less).
278	DBM & Cncl Chip 10CC/Human Allo	10cc Demineralized Bone Matrix Crunch	1 @ $2,495.00 each	$2,495.00	$2,744.50
278	Inf Bone Graft (LG) MEDTRONIC	Biologic 7510800 Inf Bone Graft LG Kit	1 @ $5,408.00 each	$5,408.00	$5,948.80
278	Hydralok Set Screws Standard	Hydralok Set Screw, Standard for 5mm-7mm	12 @ $200.00 each	$2,400.00	$2,640.00
278	Osteosponge Block 14mm	OsteoSponge Block 14mm	7 @ $637.50 each	$4,462.50	$4,908.75
278	Hydralok Rods 6.0 x 10 MM	Hydralok T1 Rod, Straight, 6mm x 100mm	2 @ $286.00 each	$572.00	$629.20

278	Inf Bone Graft MD Kit Medtronic	Biologic 7510800 Inf Bone Graft MD Kit	1 @ $4,893.00 each	$4,893.00	$5,382.30
278	Hydralok Rods 6.0 x 110MM	Hydralok T1 Rod, Straight, 6mm x 110mm	1 @ $286.00 each	$286.00	$314.60
278	Hydralok Polyaxial Screw 7.0 x 45	Hydralok Pedicle Screw, 7mm x 45 mm	2 @ $1,490.00 each	$2,980.00	$3,278.00
278	Cancellous Strip	#804 DMB osteoinductive/conductive strips	8 @ $2,100.00 each	$16,800.00	$18,480.00
278	DBM 30CC Cancellous Chips	Osteoinductive Large Cortio Cancellous Chips	1 @ $800.00 each	$800.00	$880.00
278	Buttress Screw 19-5525 5.5x25	Butress Screw 5.5 x 20	1 @ $675.00 each	$675.00	$742.50
278	Human Membrane Allograph	Amnioshield Tissue Barrier 4x4mm	2 @ $1,775.00 each	$3,550.00	$3,910.50
278	Exactech DBM W/CCC 20 CC	DBM 20cc	3 @ $4,990.00 each	$14,970.00	$16,467.00
278	Hydralok Polyaxial Screw 7x40mm	Hydralok Pedicle Screw, 7mmX40 mm	2 @ $1,490.00 each	$2,980.00	$3,278.00
278	Hydralok Polyaxial Screw 6x5mm	Hydralok Pedicle Screw, 6mmX50 mm	3 @ $1,490.00 each	$4,470.00	$4,917.00
278	Buttress Plate 15x24	Buttress Plate 15x24	1 @ $2,160.00 each	$2,160.00	$2,376.00
278	Alloquent ALIF 12 MM Allograft	Alloquent Alif Allograft – 12 mm	2 @ $3,500.00 each	$7,000.00	$7,700.00
278	Hydralok Poly Screw 5.0 x 50MM	Hydralok Pedicle Screw, 5mm X 50 mm	2 @ $1,490.00 each	$2,980.00	$3,278.00
278	Osteotech Magnifuse	Magnifuse PL	2 @ $2,750.00 each	$5,500.00	$6,050.00
278	16MM ALIF Graph Blackstone	Alloquent Alif Allograft – 16 mm	1 @ $3,500.00 each	$3,500.00	$3,850.00
				$88,908.50	$90,908.50
				Total Supported Cost	**Sum of Per-Item Add-on**

The division finds that the facility supported separate reimbursement for these implantables, and that the cost invoices were certified as required. Therefore, the MAR is calculated according to §134.404(f)(1)(B).

4. 28 Texas Administrative Code §134.404(f)(1)(B) establishes MAR by multiplying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors (including outliers) by 108%, ***plus*** reimbursement for items appropriately certified under §134.404(g). The Medicare IPPS payment rates are found at http://www.cms.gov, and the sum of the per-item add-on for which separate reimbursement was requested are taken from the table above.

- Documentation found supports the DRG assigned to the services in dispute on the original bill was DRG 454 and that the carrier subsequently reimbursed the requestor under DRG 454. Documentation found supports that the DRG assigned to the services in dispute on the corrected bill is DRG 552, and that the services were provided at Innova Hospital. Consideration of the DRG, location of the services, and bill-specific information results in total specific allowable amount of $10,105.27. This amount multiplied by 108% results in an allowable of $10,913.69.
- The total cost for implantables is $88,908.00. The sum of the per-billed-item add-ons exceeds the $2,000.00 allowed by rule; for that reason, the total allowable amount for implantables is $88,908.50 plus $2,000.00, which equals $90,908.50.

Therefore, the total allowable reimbursement for the services in dispute is $10,913.69 plus $90,908.50, which equals $101,822.19. The respondent issued payment in the amount of $126,646.71. Based upon the documentation submitted, no additional reimbursement is recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

		December 12, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		December 12, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.